

*Amanda L. Marks, LAPC*  
*Marietta Counseling for Children and Adults, LLC*  
*2440 Sandy Plains Rd. Bldg. 13, Suite 300*  
*Marietta, GA 30066*  
*770-971-9311*  
*404-455-5805*

## **Information for Clients and Informed Consent**

### **About your therapist...**

I am a licensed associate professional counselor in the state of Georgia working toward full licensure. I have a Masters degree in Psychology with a Professional Counseling Specialty. I have rich experience providing psychotherapy services for teens and adults. I receive professional supervision with Faith Arkel, LPC.

### **About Marietta Counseling for Children and Adults, LLC...**

Marietta Counseling for Children and Adults, LLC (MCCA) is a limited liability company in the state of Georgia established to provide a facility where therapists can provide counseling and psychotherapy services for children, adolescents and adults. I am contracted with MCCA to provide therapy services for children, parents, families and individual adults.

### **Benefits and Risks of Counseling....**

Benefits of counseling have been shown in many well-researched studies. People who are depressed often find their mood lifting. Anxieties preventing normal functioning can be mastered. Therapy can allow people to work through what is bothering them until their feelings are naturally resolved. Skills in relationships and communication often greatly improve. Counseling may help clients to develop and maintain a sense of balance in life followed by more lasting contentment, satisfaction and skills for coping with inevitable challenges life presents.

Risks of counseling include feeling uncomfortable levels of sadness, guilt, anxiety, frustration, loneliness, helplessness or other negative feelings as a part of the process of healing and finding way to balance. It is not uncommon (especially with children) for symptoms to worsen before improving. Clients may recall unpleasant memories.

Overall, the benefits greatly outweigh the risks. When the client and the therapist are both committed to the process of counseling, understanding therapy is not a quick fix, transformational results are often observed.

It takes great courage to begin the process of counseling. If you have any questions about what to expect in your journey through counseling with me, I am more than happy to discuss this with you not only in our first session together but throughout the process.

## Confidentiality....

It is a client's legal right that our sessions and my records about you are kept private. In all but a few situations, your confidentiality and privacy is protected by state law and by the ethical rules of my profession. There are exceptions as follows:

1. If you make serious threat to harm yourself or another person.
2. If you give me reason to believe a child or any adult dependent has been or will be abused or neglected,
3. If you are or will be involved in court proceedings and my records and/or my testimony is subpoenaed and ordered by a judge.
4. If a guardian ad litem (GAL) is appointed by a court in a custody case involving your child as my client and the court gives the GAL access to mental health records.
5. The Patriot Act of 2001 requires me in certain circumstances, to provide federal law agents with records, papers and documents upon request and prohibits me from disclosing to my client that the FBI sought or obtained the items under the Act.
6. If you choose to file through your insurance there may be a breach of your confidentiality as insurance companies do not always observe strict confidentiality policies
7. My professional supervision and/or consultation with other licensed therapist are times where I share information about my cases for purpose of gaining further perspective and ideas for how to best serve my clients without revealing names or identity. Peers, fellow therapists and any supervisor are bound by confidentiality so that any information shared does not leave the room in which it is shared and full names are not revealed.
8. Therapists and administrative staff at MCCA share office space, record storage and voicemail system.
9. If you should choose to communicate with me via email I can not guarantee your confidentiality as sometimes an email remains on a server and may be accessible by others. Please indicate your preference by circling Yes or No and signing here:

**Yes**, I understand my email is a limit to confidentiality and I do authorize you to communicate with me via email: \_\_\_\_\_

(Please provide the email address where you authorize me to send you emails: \_\_\_\_\_)

**No**, I do not authorize you to communicate with me via email. \_\_\_\_\_

9. In the case of my death or major medical incapacitation, all of my records will be accessed by Lynn Louise Wonders, LPC, RPT-S.

### More on Confidentiality:

In **working with children**, though legally the parent(s) or legal guardian(s) of child clients are the client and confidentiality lies with the client, in order to establish and preserve the essential relationship and setting for a child's therapy, I honor what the child does or says in our sessions as confidential while providing parents and/or legal guardians summaries of treatment goals, plan and progress as well as recommendations.

In **working with couples and families**, the couple as an entity and the family as an entity is my client and I am not providing individual therapy for either half of the couple or for any one member of the family although sessions with individuals in the couple/family may be a part of the couples/family therapy. ***I will not be a "secret keeper" nor will I facilitate secret keeping.*** If anything significant is revealed in an individual session that I feel the other party needs to be told, I will require it be brought up in the next session together so we can work through it or I may have to terminate the therapeutic relationship and refer you to another therapist.

## Divorce and Custody....

***\*\*I am not a custody evaluator and can not make any recommendations on custody. I can refer you to a list of licensed psychologists who provide custody evaluation if needed.\*\****

**Due to the sensitive nature of divorce and all potential issues that may arise in such cases, I have very specific policies to which you MUST agree before we enter a counseling relationship:**

1. I require a copy of the current, standing court order demonstrating custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session BEFORE I am able to meet you child. I will need to have contact with the parent who has legal custodial decision making for medical issues before I see the child for counseling and will need to obtain written consent for the child to participate in counseling from the legal custodian(s) and prefer to have contact with both parents prior to seeing the child.
2. I will be available to provide an interview with a guardian ad litem (GAL) assigned to investigate the best interest of any child I am counseling upon production of court order demonstrating the GAL's right to examine your clinical record or speak with me. Otherwise, the adult client or parents of child client will need to sign a release for me to speak with the GAL. The client will be charged a full session fee for me to have such meeting with a GAL.
3. I will provide an identical summary of a child's therapy progress, treatment plan information and parent recommendations to both parents who share in the legal custody of the child I am seeing for counseling and will offer and encourage opportunities for both parents to participate in parent consultations along the way.
4. Family sessions will likely be recommended and depending on the case, may need to see the child with each parent separately along with siblings and/or other significant family members who live in the homes where the child lives.
5. **I ask all my clients waive right to subpoena me to court.** This policy is set in order that I can preserve the efficacy and integrity of my therapeutic progress and relationship with you and/or your child(ren). It is my experience that my appearance in court often damages my therapist-client relationship and it is my ethical duty to make every reasonable effort to promote the welfare, autonomy and best interests of my clients. By signing this agreement you are waiving right to have me subpoenaed and agreeing in fact not to have me or my records subpoenaed. I will be happy to provide a referral to another therapist who will be willing to appear in court if needed as an alternative if you would prefer.
6. In the case I am subpoenaed to appear in court even with this waiver – whether I testify or not – I charge my full standard fee for Court Related work of \$150/hour of my professional time. Any of my time dedicated to any court-mandated appearance including preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance and any time spent waiting at the court house in addition to time on the stand as well as any travel time will be billed at \$150 per hour.

**I understand these policies and hereby waive any and all rights to subpoena \_\_\_\_\_ and her clinical record on any current or future legal proceedings.**

**Printed Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_**

**Printed Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_**

## Scheduling and Cancellations:

**I require 24 hours notice of cancellation of any appointment. If a client does not arrive for a scheduled appointment or cancels inside of 24 hours, there will be a charge billed for the full fee session.** On the most rare occasion there is what I consider to be a *true, absolute, unavoidable emergency* I will waive the charge.

If you or your child are contagious please call me as soon as you notice these indications as we do not wish to put other clients at risk of illness. I simply ask for 24 hours notice whenever possible. If sudden onset, call me as soon as possible and request waiver of the 24 hr. notice policy.

### **Session parameters**

Play Therapy Sessions are 45 minutes. Parenting sessions, individual counseling sessions and family sessions are 50 minutes. Sessions will start and end on time. If you arrive late, the session will still end at the scheduled time.

### **Fees, Payment, Insurance...**

All fees are paid directly to MCCA. MCCA does accept Master Card, Visa and Discover.

I am not on insurance panels; however, I will be happy to provide paperwork for you to file with your insurance company for out of network reimbursement. I can not guarantee your insurance company will reimburse for my services.

Reduced Fees are available with application and are extended based on financial need. Please ask me about reduced fee options. I am sensitive to current economic challenges and will be more than happy to discuss alternative payment agreements at our initial intake session. A reduced fee agreement will be signed once application is approved.

There is a **\$25 fee for any returned checks.** That \$25 fee is due at the time of your next session, along with the payment for that session. If I receive two (2) returned checks from you, I will require that you pay using cash or credit card only from that point on.

#### Standard Fees:

Initial Intake Session: \$100

All other Sessions: \$100

Phone or Email Communications initiated by client exceeding ten minutes will be pro-rated and billed at the relevant session rate.

Preparation of Summaries of Treatment or Letters at request of client: \$75 per item requested.

Court Related and/or Child Specialist Work for Collaborative Law Cases: \$150/hour of any and all time spent on the case.

**I do require payment of fees be made at the beginning of each session** so business can be out of the way in order to sink into the issues the client needs/wants to address during the session.

### **After Hour Support and Emergencies...**

**Marietta Counseling for Children & Adults, LLC is not an emergency services agency. I do not provide emergency services. If you have a life threatening or mental health emergency please call 911.** After you call 911 you may call me during business hours at 770-971-9311 ext. 3 and leave me a confidential voicemail including your phone number even if you know that I have it along with a brief message. I will call you back when I have finished all sessions and business with other clients or between sessions if possible and if not possible the same day that you leave the message, as soon as I can the next business day. When I am away from the office for extended time, my outgoing voicemail message will reflect when I will be back. I also provide all clients in advance my away-from-office dates.

**Other after hour Mental Health Resources (not to be substituted for calling 911 with emergency):**

Ridgeview Institute at 770.242.4567  
Peachford Hospital at 770.454.5589  
Cobb Mental Health Crisis Line 770.422.0202  
Fulton Mental Health Crisis Line 404.730.1600

**My Records...**

You should be aware that, pursuant to HIPAA, I keep information about all of my clients in a collection of professional records. This constitutes your Clinical Record. I keep brief notes indicating the date and time of your session, issues/themes observed in session, interventions utilized, treatment plan, fees charged and paid. You may schedule an appointment to examine your Clinical Record. Additionally, you may receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted by untrained readers. For this reason, I recommend that you initially review them in my presence within a scheduled session, or have them forwarded to another mental health professional so you can discuss the contents. There will be an administrative fee of \$35 charged for copying and mailing the record for release.

**Client Rights...**

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and the privacy policies and procedures. A copy of your HIPAA rights are located in a blue binder in our lobby for your review or we can provide a copy to you at any time.

**Complaints or Grievances...**

If you feel that there is basis for a formal complaint or grievance about anything related to the professional services I am providing, I invite you to first communicate your concerns to me directly so that I will be informed and have an opportunity to respond and resolve any potential misunderstanding. You have a right to file a complaint about me with my licensing board and may do so by contacting the board at the following address and phone number:

**Georgia Composite Board of Professional Counselors,  
Social Workers, and Marriage and Family Therapists**  
237 Coliseum Drive Macon, GA 31217-3858 (478) 207-2440

**Our Agreement To Enter into Counseling Services....**

I have read or had read to me all the information in this above paperwork pages 1 - 5, have initialed the bottom of each page of this agreement indicating that I have read them and understand them, have had a chance to review and ask questions and have had all questions answered to my satisfaction. I agree to abide by all the policies outlined herein. By signing this agreement, I am consenting to treatment and understand all the benefits and risks of counseling as outlined herein. I also hereby acknowledge that I have received the HIPAA notice form mentioned herein.

Printed Name of Client: \_\_\_\_\_

If Child Client Name of Legal  
Guardian/Parent: \_\_\_\_\_

Signature of Client or Legal Guardian/Parent of Child  
Client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Therapist: \_\_\_\_\_ Date: \_\_\_\_\_

CLIENT CONTACT INFO:

Name of Client \_\_\_\_\_ Client's Date of Birth \_\_\_\_\_

Date of your first counseling session with Amanda L. Marks, LAPC \_\_\_\_\_

Parent/Custodian if client is child \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Approval to leave voicemail? \_\_\_\_\_

Person in case of emergency you authorize me to contact (name, relationship and number)

Mailing Address \_\_\_\_\_ Approval to mail to this address? \_\_\_\_\_

Email Address \_\_\_\_\_ Approval to contact you via email? \_\_\_\_\_

How did you hear about me and my services? \_\_\_\_\_

What is the primary reason you are seeking counseling services at this time?

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When did you first notice the issue/problem that brings you to counseling? (please provide a date if possible)

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Are you currently on any medications and if so which one(s)?

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Significant medical history:

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Have you ever been in counseling before? If so, when and for how long?

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If you have been in counseling before, what was your reason for discontinuing counseling? What seemed to work for you in that counseling experience and what did not work for you?

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What do you hope to accomplish by coming to counseling?

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Any thing else you would like me to know before we begin our work together?

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## **PRIVACY PROTECTION NOTICE**

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

*This notice shall go into effect January 1, 2008 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.*

### **I. Preamble**

A recent United State Supreme Court decision held that communications between psychotherapists and their clients are privileged and, therefore, are protected from forced disclosure in cases arising under federal law. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the client himself/herself. HIPAA provides privacy protections about your personal health information, which is called "protected health information" (PHI) which could personally identify you. **PHI consists of three (3) components: treatment, payment, and health care operations.**

**Treatment** refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

**Payment** is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided you.

**Health care operations** are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary."

The **use** of your protected health information refers to activities my office conducts for filing your claims, scheduling appointments, keeping records and other tasks *within* my office related to your care. **Disclosures** refer to activities you authorize which occur *outside* my office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

### **II. Uses and Disclosures of Protected Health Information Requiring Authorization**

The law requires authorization and consent for treatment, payment and healthcare operations. I may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you). Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon the request. The requirement of your signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might be your request that I talk to your child's schoolteacher about his/her ADHD condition and what this teacher might do to be of help to your child. Before I talk to that teacher, you will have first signed the proper authorization for me to do so. There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychotherapist-client in treatment settings, HIPAA permits keeping separate "psychotherapy notes" separate from the overall "designated medical record." "Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services as has unfortunately occurred over the last two decades of managed mental health care. "Psychotherapy notes" are *my* notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at my office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished,

results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date. Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time I will be able to limit reviews of your protected health information to only your “designated record set” which include the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of you care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests, which are protected by copyright laws and the need to protect clients from unintended, potentially harmful use, are not part of your “designated mental health record.” You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and the insurer has the right to contest the claim under the policy.

### **III. Business Associates Disclosures**

HIPAA requires that I train and monitor the conduct of those performing ancillary administrative service for my practice and refers to these people as “Business Associates.” I do employ business associates to assist with my administrative matters and these business associates are indeed trained and monitored so that your privacy is ensured at all times.

### **IV. Uses and Disclosures Not Requiring Consent nor Authorization**

By law, protected health information may be released without your consent or authorization for the following reasons:

- Child Abuse
- Suspected Sexual Abuse of a Child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., licensing board for Professional Counselors in Georgia)
- Judicial or Administrative Proceedings (i.e., if you are ordered here by the court)
- Serious Threat to Health or Safety (i.e., out “Duty to Warn” Law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

I never release any information of any sort for marketing purposes.

### **V. Client’s Rights and My Duties**

You have a right to the following:

- *The right to request restrictions* on certain uses and disclosures of your protected health information, which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
- *The right to receive confidential communications by alternative means and at alternative locations.* For example, you may not want your bills sent to your home address so I will send them to another location of your choosing;
- *The right to inspect and receive a copy* of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the records;
- *The right to amend* material in your protected health information, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care;
- *The right to an accounting of non-authorized disclosures* of your protected health information;
- *The right to a paper copy* of notices/information from me, even if you have previously requested electronic transmission of notices/information; and
- *The right to revoke your authorization* of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointment(s). My duties as a Licensed Professional Counselor on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and my privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. If for some reason you desire a copy of my internal

policies for executing private practices, please let me know and I will get you a copy of these documents I keep on file for auditing purposes.

**VI. Complaints**

I am the appointed “Privacy Officer” for my practice per HIPAA regulations. If you have any concerns of any sort that my office may have compromised your privacy rights, please do not hesitate to speak to me immediately about this matter. You will always find me willing to talk to you about preserving the privacy of your protected mental health information. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

**CLIENT NOTIFICATION OF PRIVACY RIGHTS**

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPAA provides client protections related to the electronic transmission of data (the transaction rules), the keeping and use of client records (“privacy rules”), and storage and access to health care records (“the security rules”). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don’t have formal legal training. My Client Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received the Client Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Lynn Louise Wonders, MA, LPC, RPT-S, RYT  
Privacy Officer

I, \_\_\_\_\_, understand and have been provided a copy of the Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

\_\_\_\_\_  
Client Signature or Parent if Minor or Legal Charge Date  
If Legal Charge, describe representative authority: \_\_\_\_\_

**PATIENT RECORD OF DISCLOSURES**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request

confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual home. Please complete only the top half of this form.

**I wish to be contacted in the following manner (check all that apply):**

**Home Phone Number:** \_\_\_\_\_  
 OK to leave message with detailed information  
 Leave message with name & call back number only  
 Do not leave messages at home number \_\_\_\_\_

**Written Communication**  
 OK to mail to my home address  
 OK to mail to my work/office address  
OK to fax to this number \_\_\_\_\_

**Work Phone Number:** \_\_\_\_\_  
 OK to leave message with detailed information  
 Leave message with name & number only  
 Do not call me at work

**Cell Phone Number** \_\_\_\_\_  
 OK to leave message with detailed info  
 Leave message with name & number only  
 Do not call me at this number.

\_\_\_\_\_  
Parent/Guardian Signature and Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record. **NOTE: USES AND DISCLOSURES MAY BE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY.**

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**Fees for Services Agreement**

**ALL CLIENTS MUST FILL OUT THIS FORM in its ENTIRETY PLEASE**

Every time I schedule an appointment with my therapist at MCCA I understand that I am entering into a contract with Marietta Counseling for Children & Adults, LLC (MCCA) and for the professional time and services provided for that appointment time. I recognize that professional services are not only provided during my appointment time but also during the 24 hours prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, confidential consultations with other professionals as agreed in writing by me to assist with my treatment. I understand my therapist's professional fees as outlined in our Agreement to Enter into Counseling Services for scheduled sessions. I understand I have a right to request information about reduced fee options at any time. At this time my therapist and I have agree that my fee for sessions will be \$\_\_\_\_\_ and I agree to pay this fee at the beginning of my session. I understand that MCCA does not reimburse for canceled appointments that were paid for in advance but that any such fees will be credited to your account and applied to future services provided.

I understand that MCCA's cancellation policy requires 24 hours advance notice in order to be released from the contract for my therapist's time and services of preparation for my session. **I agree that if I fail to cancel my appointment within the 24 hour minimum time period prior to my session I will be charged a full session fee for the appointment. I hereby authorize MCCA to charge my Visa/ Master Card/ Discover/ American Express (circle one) credit card number \_\_\_\_\_ exp. date \_\_\_\_\_ cvcode \_\_\_\_\_ zip code \_\_\_\_\_ if I indeed fail to observe this cancellation policy.** I also understand if there is an emergency situation that prohibits me from canceling within 24 hours I can discuss this with Amanda directly and request a waiver of this policy but I understand that Amanda is not bound to grant that waiver and may by this contract proceed with charging my credit card as agreed herein.

Client (or parent/legal guardian of child client) Printed Name \_\_\_\_\_

Client (or parent/legal guardian of child) Signature and date \_\_\_\_\_

Therapist Amanda L. Marks' Signature and date \_\_\_\_\_

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#### **Directions**

**From I-75 Northbound:** Exit 267A. At first light you will turn right onto Sandy Plains Rd. Go through 5 stop lights. Pass Keswyck Commons neighborhood on the right, pass Mozelle St. and then a grave yard on your right you will look for the big Travel sign and turn right into the red brick office park. Go to the first stop sign and turn right. Building 13 is on your right.

**From I-75/5-75 Southbound:** Exit 267A toward Canton Hwy. At first light you will turn right onto Sandy Plains Rd. Go through 5 stop lights. Pass Keswyck Commons neighborhood on the right, pass Mozelle St. and then a grave yard on your right you will look for the big Travel sign and turn right into the red brick office park. Go to the first stop sign and turn right. Building 13 is on your right.

**From Barrett Parkway/Kennesaw:** Travel southeast on Barrett. It will turn into East Piedmont. As you approach Sprayberry H.S. on your right you will turn right onto Sandy Plains Road. Turn left at the break in the median onto First and then take an immediate right into the office park. Proceed through the stop sign and building 13 will be on the right.

**From East Cobb:** Travel East Piedmont off of Sewell Mill or 120 heading northwest until you come to Sandy Plains Rd. Turn left onto Sandy Plains Rd. and then turn left at the break in the median onto First. Take an immediate right into the office park. Proceed through the stop sign and building 13 will be on the right.

**From Woodstock and Roswell:** From 92 take Sandy Plains Road west to East Piedmont. Cross over East Piedmont. Turn left at the break in the median onto First. Take an immediate right into the office park. Proceed through the stop sign and building 13 will be on the right.

**From West Cobb or Marietta Square:** From Marietta Square make your way toward Kennestone Hospital passing Kennestone on your left and crossing over I75 on Canton Hwy. At first light you will turn right onto Sandy Plains Rd. Go through 5 stop lights. Pass Keswyck Commons Neighborhood and just past Mozelle St. and then a grave yard on your right you will look for the big Travel Leaders sign and turn right into the office park. Go to the first stop sign and turn right. Building 13 is on your right.